This section includes the following EZ/EC Health Benchmarking Demonstration Project materials relevant to organizing a health improvement initiative.

SELF-ASSESSMENT CHECKLIST

The Self-Assessment Checklist is designed to be a brief overview of community activities that comprise needs and assets assessment. Community assessment involves engaging the community, identifying community health needs and assets, determining priorities, setting benchmarks and communicating the assessment conclusions. Each component is viewed as essential to success in community benchmarking. Attached is a Self-Assessment Checklist designed to enable communities to gauge where they are in the process and where they need to start. Using a self-assessment tool early in the needs and assets assessment process assists with strategic decisions about where technical assistance resources will be most helpful.

Engaging communities implies the community is defined, that there is an interface between health care planners, policy makers, and providers with the community. The community is made up of several entities – people, organizations, locations, and formal and informal networks. An advisory group that will guide the needs and assets assessment is generally used. An advisory group promotes an early investment from the change agents, involves those whose health will be improved, and provides a structure for the assessment process.

Identifying community health needs and assets is the core community needs assessment activity. Quantifying, verifying, and documenting findings allow a systematic approach to the task of fact finding. Subjective and objective findings are compared. Findings from several sources are synthesized. Gaps are identified.

Determining priorities involves taking all the issues that the community could address and setting some rubrics for deciding where to begin. Community values, resources, and the state-of-knowledge are all applied to the ordering of potential activities. Factors such as importance, feasibility, asset characteristics, and doability are considered in the priority setting phase.

Setting benchmarks is critical to knowing where the community wishes to go. Benchmark measures are quantifiable, objective, and time limited. Benchmarks represent an end product of determining what is important to measure and what is the target amount of change desired. Benchmarks allow any audience to track progress. Community participants committed to changing health indicators are also encouraged to adopt a benchmark approach for their respective constituencies.

Communicating conclusions is useful in creating a broad sense that the entire community is in agreement on where it is going to focus attention and improve health. A planned communication strategy allows the thoughtful formation of a message, strategies to raise awareness and guides to participation.

This Self-Assessment Guide deals with the health improvement process only through the step of setting benchmarks. Implementation strategies and action plans are the next logical steps for communities to take. Without a solid implementation of efficacious and effective interventions, goals are not met.

SELF-ASSESSMENT CHECKLIST

Check, in the appropriate box, the level currently underway on each activity and indicate whether technical assistance may be desired.

Needs and Assets Assessment Activity		Current Activity Level			Assistance Requested (Yes/No/ Not Sure)
		None √	Low √	High √	
Engaging Community Partners for EZ/EC Assessment					
	Advisory group recruitment				
	Advisory group appointment				
	Advisory group has a mission				
	Advisory group is informed				
	Advisory group has a written plan				
	Advisory group has an administrative structure for accomplishing work				
	Advisory group staffing identified				
	Resources for assessment activities identified				
	Expertise identified				

SELF-ASSESSMENT CHECKLIST

Needs and Assets Assessment Activity		Current Activity Level			Assistance Requested (Yes/No/ Not Sure)
		None √	Low √	High √	
Identifying Health Problems and Community Needs					
	List of specific health issues and contributing factors				
	Collect previous assessment and reports of health				
	Inventory of data sources				
	Access to needed data				
	List measures desired from each data source				
	Gaps in available data identified				
	Data collection to fill gaps				
	Health status assessment				
	Synthesis of data around issue areas- target population, disease, outcomes				
	Assets inventoried				
	Examine the policy environment				
	Written conclusions including areas which need attention				

SELF-ASSESSMENT CHECKLIST

Needs and Assets Assessment Activity		Current Activity Level			Assistance Requested (Yes/No/ Not Sure)
		None √	Low √	High √	
Determining Priorities					
	Criteria for priority setting (feasibility, importance, etc.)				
	List of recommendations based on need conclusions				
	Ascertainment of intervention partners and assets mapping				
	Assessment of intervention partner involvement				
	Specification of intervention points and expected outcomes				
	Prioritize recommendations				

Needs and Assets Assessment Activity		Current Activity Level			Assistance Requested (Yes/No/ Not Sure)
		None	Low	High	
Setting Benchmarks					
	Determine who will select benchmark(s)				
	Review of possible measures				
	Select measure(s)				
	Compare status quo with ideal, "best," average, or neighbors				
	Identify data source(s)				
	Generate calculations of various implementation scenarios				
	Select benchmark for community				

SELF-ASSESSMENT CHECKLIST

Needs and Assets Assessment Activity		Current Activity Level			Assistance Requested (Yes/No/ Not Sure)
		None √	Low √	High √	
Communicating Conclusions					
	Communication plan for dissemination of conclusions				
	Written assessment report				
	Short report of conclusions				
	Presentation to community, intervention partners, policy makers				
	Create opportunities to be part of the health improvement process				

EXAMPLE ¾ PROJECT ASSISTANT JOB DESCRIPTION (DENVER, CO)

Example Job Description – Project Assistant

The Project Assistant will be a detail-oriented self-starter who will assure the day-to-day operations of the EZ/EC Health Benchmarking Project in the Denver Enterprise Community. The Project assistant will interact with the Enterprise Community Coordinator, the Denver Health Director of Community Health Services, and the Denver Health Director of Government Relations.

Performance Objectives:

1. Develop a strong grasp of project and office policies, procedures, systems, and equipment in order to handle all aspects of the job effectively.
2. Provide assistance to the team, handling assigned tasks with attention to detail and consistently ensuring completeness and accuracy.*
3. Develop a general understanding of and be able to communicate to constituents, the EZ/EC Health Benchmarking Project's role, activities, and relationship within the Denver community. Begin to build a knowledge of group dynamics and group process, the community, economic development, and of the public health field in general.
4. Increase working knowledge of MS Word and Power Point and ability to integrate documents from these and other packages.
5. Develop and routinely practice strong communication skills and habits with the project team to help ensure effective coordination of project tasks, workload, and deadlines.

* Assigned activities will include: research (including web searches); developing and organizing briefing materials; handling meeting logistics; preparing and coordinating postal, fax, and electronic mailings; arranging and coordinating schedules for meetings, conference calls, and phone interviews; establishing group lists and mail merges; drafting routine memos and correspondence; data entry; assisting in designing and managing spreadsheets and data bases to track work status; taking notes; photocopying; and other project, research, and clerical tasks as assigned.

Mission Statement

To engage area partners in active pursuit of health improvements in the New Haven Enterprise Community

ANNOTATED LIST OF REFERENCES

The following is an annotated list of references related to the EZ/EC Health Benchmarking Project. It is intended to aid EZ/EC's in identifying resources to support community needs/assets assessment and benchmarking. The annotation includes abstracts, excerpts, or key findings from the source. The references—which include journal articles, published reports, organizations, and web sites—are organized according to the following categories: engaging community partners; identifying community health needs and assets; determining priorities; and setting benchmarks or targets that reflect the priorities, assets, and motivation of the community. The categories, and hence the references, should not be considered mutually exclusive, as each category is an integral, and interrelated component of community health assessment and benchmarking. For example, some references are excellent sources of information on the whole process of identifying needs, determining priorities, setting targets, and developing community action plans or strategies.

Engaging Community Partners

- American Cancer Society (National Advisory Group on Collaboration with Organizations). *A Collaboration Guidebook,* 1996.

  Common factors in successful collaborations:

  - Mutually agreed upon, clearly defined shared vision or guiding purpose
  - Competence
  - Mutual respect, tolerance, and trust
  - Skilled leadership
  - Active involvement of participants/attention to the process
  - Clearly defined roles, responsibilities, and operating procedures
  - Diversity and inclusion
  - Respect for differences
  - Good communications
  - Early success
  - Conflict resolution
  - Adequate resources

- Coalition for Healthier Cities and Communities. c/o Health Research, Education, and Trust, One North Franklin, Chicago, Illinois 60606 (312) 422-2635

  The coalition is a partnership of entities from the public, private and non-profit sectors collaborating to focus attention and resources on improving the health and quality of life of communities through community-based development.

- Goodman, R.M., Speers, M.A. et al. "Identifying and Defining the Dimensions of Community Capacity to Provide a Basis for Measurement." *Health Education and Behavior,* 25(3): 258-278, 1998.

  Dimensions of community capacity for program development, implementation and evaluation:
  - Citizen participation
  - Leadership
  - Skills
  - Resources
  - Social and inter-organizational networks
  - Sense of community
  - Understanding of community history
  - Community power
  - Community values
  - Critical reflection

- Kegler, M.C., Steckler, A. et al. "Factors that Contribute to Effective Community Health Promotion Coalitions: A Study of 10 Project ASSIST Coalitions in North Carolina." *Health Education and Behavior,* 25(3): 338-353, 1998.

  "The results suggest that coalitions with good communication and skilled members had higher levels of member participation. Coalitions with skilled staff, skilled leadership, good communication, and more of a task focus had higher levels of member satisfaction. Coalitions with more staff time devoted to them and more complex structures had greater resource mobilization, and coalitions with more staff time, good communication, greater cohesion, and more complex structures had higher levels of implementation."

- Milio, N. "Priorities and Strategies for Promoting Community-Based Prevention Policies." *Journal of Public Health Management and Practice,* 4(3): 14-28, 1998.

  "Policy making requires a grasp of the interplay among stakeholders, policy makers, the press, and the public. A framework for gathering relevant information and guiding strategic action is a useful tool for participation in community, state, and national arenas in the interests of population health."

- Norris T. "Healthy Communities." *National Civic Review,* 86(1):3-10, 1997.

  The author suggests that what works best to create and sustain positive community change can ultimately be defined in a local context. Six emerging common characteristics and qualities are described:

- Successful communities recognize that the health and sustainability of a community are products of the whole community working, not a result of isolated interventions in any single sector.
- Successful communities engage everybody and build ownership and civic engagement.
- Successful communities take a regional and a local approach…simultaneously.
- Successful communities know how they are performing.
- Successful communities start with a shared vision and follow with a specific action plan and implementation strategy.
- Successful communities build on existing resources and look at systemic change."

- Institute of Medicine (Committee on Public Health). *Healthy Communities: New Partnerships for the Future of Public Health*. National Academy Press, Washington, D.C., 1996.

  "The Committee's analysis…the public's health depends on the interaction of many factors; thus, the health of a community is a shared responsibility of many entities, organizations, and interests in the community, including health delivery organizations, public health agencies, other public and private entities, and the people of a community."

- U.S. Department of Health and Human Services, Centers for Disease Control and Prevention (CDC/ATSDR Committee on Community Engagement), *Principles of Community Engagement*, Atlanta, Georgia, 1997

  Principles of Community Engagement provides public health professionals and community leaders with a science base and practical guidelines for engaging the public in community decision-making and action for health promotion, health protection, and disease prevention. The document was prepared for public health professionals and community leaders within organizations, rather than a more grass-roots audience.

- Voluntary Hospitals of America, Inc. *VHA's Voluntary Community Benefits Standards: A Framework for Meeting Community Health Needs*, 1993.

  Standard #1: Demonstrate leadership as a charitable institution
  Standard #2: Provide essential health care services
  Standard #3: Be accountable to the community
  Standard #4: Evidence commitment to community benefit
  Standard #5: Operate free from private profit

Identifying Community Health Needs and Assets

- McGinnis JM and Foege WH. "Actual causes of death in the United States". Journal of the American Medical Association 270 (18): 2207-2212, 1993.

  Approximately half of all deaths could be attributed to various risk factors. Actual causes of death were determined to be, in order of importance:

  1- Tobacco
  2- Diet/inactivity
  3- Alcohol
  4- Infections
  5- Toxic agents
  6- Firearms
  7- Sexual behavior
  8- Motor vehicles
  9- Drug use

- McKnight JL and Kretzmann J. *Mapping community capacity.* Evanston, IL: Center for Urban Affairs and Policy Research, Northwestern University, 1990.

  A neighborhood assets map is made up of primary, secondary, and potential building blocks.

  Primary: Assets and capacities located inside the neighborhood, largely under neighborhood control.

  Secondary: Assets located within the community, but largely controlled by outsiders.

  Potential: Resources originating outside the neighborhood, controlled by outsiders.

- National Civic League web-site <www.ncl.org> Includes information on Healthy Communities Initiatives; Program for Community Problem Solving; a Healthy Communities Toolbox; and Healthy Communities publications.

  "Though all Healthy Communities initiatives look different, there are several key elements of successful initiatives: utilization of a broad definition of health; broad-based community involvement; development of a shared vision; and a real change in how systems in the community operate and relate to one another."

- Norris, T. "Creating the Building Blocks for Health." *Trustee,* April: 16-18, 1995.

  What creates health? (Based on a nationally representative survey of 1,000 Americans from all socioeconomic groups. DYG INC/Healthcare Forum, 1994)

Low crime	73%	High environmental quality	65%
Good place to bring up children	73%	Good jobs and healthy economy	64%
Low level of child abuse	72%	High-quality health care	61%
Not afraid to walk at night	71%	Affordable health care	60%
Good schools	71%	Good access to health care	60%
Strong family life	70%	Excellent race relations	54%

- Tong, DA. "Beyond Prevention: Healing the 'Sociomas'." Healthcare Forum Journal, May/June, 1996.

  "…patients show up every day at Greater SE Community Hospital with acute and chronic cases of what has been called the "sociomas" – social problems ranging from drug addiction to homelessness, and the despair that accompanies miserable life circumstances…. We have begun by building on past efforts, renewing and deepening our commitment to cost-effective primary-care and disease prevention programs in the inner city."

- US Conference of Mayors (HIV Program). Needs Assessment for HIV/AIDS Prevention and Service Programs: Gathering Information to Determine Needs, 1993.

  Three common methods of information collection:

  1. Social and Health Indicator Analysis

  Social and health indicators are aggregate statistical measures that depict significant aspects of a social situation and the health status of the population in the community. Examples of this type of data include incidence and prevalence data, census statistics on racial and ethnic household composition and size, income level, hospitalizations, and arrests.

  2. Social Area Surveys

  Surveys provide a means for identifying information about a community or target population, service providers, and other groups. There are three types of survey methods generally used in needs assessments:
  - Mail questionnaires
  - Face-to-face interviews
  - Telephone interviews

  3. Structured Groups
  - Focus groups
  - Nominal groups
  - Delphi panels
  - Community forums and public hearings

- Greenberg M., Lee C., Powers C. "Public Health and Brownfields: Reviving the Past to Protect the Future." American Journal of Public Health. December 1998 Vol. 88 No. 12.

- Green, M. "Asset-Based Community Development – A Neighborhood Leaders Guide 6." Resource Journal. The Neighborhood Resource Center of Metropolitan Denver (http://www.nrc-neighborhood.org/rj6.html).

- Mourad, M. Comprehensive Community Revitalization Community Based Neighborhood Planning & Strategies for Asset-Building—An Overview. "Building Individual and Community Assets." pp. 20-29. The Enterprise Foundation. 1998.

Determining Priorities

- Centers for Disease Control and Prevention. Health Status Indicator Reports: "State of the Art." Healthy People 2000: Statistics and Surveillance Report No 8: 1-4, 1996.

  Maryland developed consensus matrices to prioritize indicators based on comparisons for each county. Two comparisons were made for each indicator. The first compared the county's rates to the State's rates for the past five years. The second comparison was between the 5-year county trend compared to the State trend over the same period. Priorities were assigned based on the joint category. Highest priority was given to health indicators that had rates greater than the State and a worse trend when compared to the State.

- National Association of County and City Health Officials, Assessment Protocol for Excellence in Public Health, Washington, DC, March 1991.

  The Assessment Protocol for Excellence in Public Health (APEXPH) project, funded by a cooperative agreement from the Centers for Disease Control and Prevention (CDC) to NACCHO, was designed and tested through a collaborative effort of national public health organizations over a four-year period. A comprehensive public health assessment and planning process, APEXPH was developed to be used voluntarily by local health officials to assess the organization and management of the health department, provide a framework for working with community members and other organizations in assessing the health status of the community, and establish the leadership role of the health department in the community.

- Studnicki, J., Steverson, B., et al. "A Community Health Report Card: Comprehensive Assessment for Tracking Community Health (CATCH)." Best Practices and Benchmarking in Health Care, 2(5):196-207, 1997.

  A systematic method for assessing the health status of communities has been under development at the University of South Florida since 1991. The system, known as CATCH, draws 226 indicators from multiple sources and uses an innovative comparative framework and weighted criteria to produce a rank-ordered community problem list. The CATCH results from 11 Floridian counties have focused attention on high priority health problems and provided a framework for measuring the impact of health expenditures on community health status outcomes.

- U.S. Department of Health and Human Services, Centers for Disease Control and Prevention, National Center for Chronic Disease Prevention and Health Promotion, Planned Approach to Community Health: Guide for the Local Coordinator, Atlanta, Georgia.

  The Planned Approach to Community Health (PATCH) is a community health planning model that was developed in the mid-1980s by the Centers for Disease Control and Prevention (CDC) in partnership with state and local health departments and community groups. The goal of PATCH is to increase the capacity of communities to plan, implement, and evaluate comprehensive, community-based health promotion programs targeted toward priority health problems.

- Vilnius D. and Dandoy S. "A Priority Rating System for Public Health Programs." Public Health Reports, 105(5):463-470, 1990.

  When resources are limited, decisions must be made regarding which public health activities to undertake. A priority rating system, which incorporates various data sources, can be used to quantify disease problems or risk factors, or both. The model described in this paper ranks public health issues according to size, urgency, severity of the problem, economic loss, impact on others, effectiveness of interventions, propriety, economics, acceptability, legality of solutions, and availability of resources. Rankings have been applied to the following health issues: AIDS, coronary heart disease, injuries from motor vehicle accidents, and cigarette smoking as a risk factor.

Setting Benchmarks

- American Public Health Association. Healthy Communities 2000: Model Standards, 3rd Edition. Washington, D.C., 1991.

  Identifies guidelines for community attainment of the Year 2000 national health objectives. Includes chapters on special population age groups: children, adolescents and young adults, adults, and older adults.

- Healthy People 2010 Website, http://www.health.gov/healthypeople.

  Provides up-to-date fact sheets, information on Healthy People Consortium activities, updated public comments on the draft objectives, staff contacts, and other information related to development of Healthy People 2010 objectives.

- Institute of Medicine (Committee on Using Performance Monitoring to Improve Community Health). Improving Health in the Community: A Role for Performance Monitoring. National Academy Press, Washington, D.C., 1997.

  Based on its review of the determinants of health, the community-level forces that can influence them, and community experience with performance monitoring, the committee finds that a community health improvement process (CHIP) that includes performance monitoring, as outlined in this report, can be an effective tool for developing a shared vision and supporting a planned and integrated approach to improve community health.

- National Research Council (Panel on Performance Measures and Data for Public Health Performance Partnership Grants, E.B. Perrin and J.J. Koshel eds.) Assessment of Performance Measures for Public Health, Substance Abuse and Public Health. National Academy Press, Washington, D.C., 1997.

  "There appears to be a growing consensus within public health, substance abuse, and mental health communities about the value of performance measurement. Indeed, many people believe the case for increasing, or even maintaining, public funding will depend on documented program performance."

- Oregon Progress Board. Oregon Benchmarks: Standards for Measuring Statewide Progress and Institutional Performance (Report to the 1995 Legislature). December, 1994.

  Oregon Benchmarks are the measurable indicators that Oregon uses at the statewide level to assess its progress toward broad strategic goals. In 1994, the program was one of 10 winners out of 1,350 applications of the annual Innovations in Government awards presented by the Ford Foundation and the Kennedy School of Government at Harvard University.

- U.S. Department of Health and Human Services, Office of Disease Prevention and Health Promotion. Developing Objectives for Healthy People 2010, 1997, September. (Available at http://odphp.osophs.dhhs.gov/pubs/hp2000)

  A resource guide for individuals and groups to use in reviewing and modifying Year 2000 objectives, as well as developing new objectives. Includes updated tracking data.

- U.S. Department of Health and Human Services, Office of Disease Prevention and Health Promotion. Improving the Nation's Health With Performance Measurement, Prevention Report Vol. 12(1):1-5, 1997.

  Performance Measurement: Step by Step

  Step1: Relate the performance measure to an important national, state, or local health priority area.
  Step 2: Measure a result that can be achieved in 5 years or less.
  Step 3: Ensure that the result is meaningful to a wide audience of stakeholders.
  Step 4: Define the strategy that will be used to reach a result.
  Step 5: Define the accountable entities.
  Step 6: Draft measures that meet statistical requirements of validity and reliability and have an existing source of data.

- U.S. Department of Health and Human Services, Office of Disease Prevention and Health Promotion. Healthy People 2000: Consortium Action, 1992. Washington D.C.: U.S. Government Printing Office.

  Describes activities that support the national health objectives arising from the more than 325 national membership organizations of the Healthy People 2000 Consortium.

Communicating Conclusions

- Brownson RC, Remington PL, and Davis JR. Chronic Disease Epidemiology and Control. American Public Health Association, Washington, D.C., 1993.

Step	Question	Action
1	What should be said?	Establish the message.
2	To whom should it be said?	Define the audience.
3	What communications medium should be used?	Select the channel.
4	How should the message be stated?	Market the message.
5	What effect did the message create?	Evaluate the impact.

  "… the message must be framed as a simple, declarative statement. The term SOCO has been used to describe this Single Overriding Communication Objective."

- DiFranza JR, the Advocacy Institute, and the Center for Strategic Communications. Strategic Communications for Non-Profits: A Researcher's Guide to Effective Dissemination of Policy-Related Research, October 1996. Princeton, NJ: Robert Wood Johnson Foundation.

  Provides guidance on working with the mainstream press:
  - Who to call
  - What to say and how to say it
  - How to package your research for the press
  - When to call
  - After the story is sold
  - Sharing the spotlight
  - Getting help
  - Working with nonprofit organizations
  - Colleagues

- Lasker RD and the Committee on Medicine and Health. Medicine and Public Health: The Power of Collaboration. New York, NY: The New York Academy of Medicine, 1997.

  … collaborations around health promotion and health protection take five forms:
  - Community health assessments
  - Public education campaigns
  - Health-related laws and regulations
  - Community-wide campaigns to achieve health promotion objectives
  - "Healthy Community" initiatives

- Sutherland C. "Criteria for Rating Report Card Quality," 1998. Personal communication.

  (1) Organization of the report, (2) presentation of data, (3) use of graphics, (4) balanced interpretation (needs and assets are both portrayed), and (5) indicators are contextualized (narrative is provided on indicators) are the five criteria for rating report card quality. If all elements are present, then the rating is "Good"; if the elements are present and of outstanding quality, then the rating is "Excellent."